STATE OF RHODE ISLAND AND
PROVIDENCE PLANTATIONS,
DEPARTMENT OF HEALTH,
BOARD OF MEDICAL LICENSURE
AND DISCIPLINE C94-029

In the matter of:
Clayton D. Lanphear III, D.O.

CONSENT ORDER

Pursuant to §5-37-5.2 of the General Laws of the State of Rhode Island, 1956, as amended, (1987 Reenactment), a complaint was filed by the Division of Facilities Regulation with the Board of Medical Licensure and Discipline (hereinafter referred to as "Board") alleging Clayton D. Lanphear III, D.O., Respondent, committed "unprofessional conduct" as defined in §5-37-5.1. An investigation was conducted by Investigating Committee I, so called, of the Board.

The following constitutes the Investigating Committee's Investigative Findings with respect to the professional conduct of the Respondent.

Investigative Findings

1. A 98 year-old female patient was admitted to a local nursing care facility on September 28, 1993 and was seen the next day by the Respondent, who was the patient's physician and the Medical Director of the facility. The Respondent did

not write a history and did not complete the physical examination, which had 13 areas to be examined, as required by the facility. The diagnostic impression was dementia and abdominal aneurysm. The Respondent wrote admission orders for medications, laboratory tests and treatments for this patient. The nursing admission record noted that the skin was intact and the coccyx was slightly reddened.

2. Twenty-two days after the patient was admitted, the Respondent was at the facility when the nursing staff notified him that the patient had a necrotic area on her left knee and over her coccyx. Elase ointment was ordered to debride the areas.

3. Seven days after the initial notification, while at the facility, the Respondent was notified that the areas were not responding to treatment. The Respondent called in a surgeon who debrided the areas.

4. Two weeks after the initial notification the Respondent saw the patient and decided to give the treatment more time to work.

5. On November 12, 1993, three weeks and three days after the initial notification the patient was transferred to an acute care facility. There was a bed sore which was large and open over the coccyx. Additionally, there was necrotic tissue on the leg. The patient expired at the acute care facility on November 23, 1993.

6. The Department of Health reviewed medical records of the residents at the facility. The Respondent had obligations

for these patients as the attending physician and Medical Director of the facility. The investigation revealed the following:

a) the records contained dates which were illegible or incorrect and notes which were illegible;

b) the records did not meet the minimum standards for assessment and treatment of patients in a long term care facility;

c) physical examinations upon admission, which were the responsibility of the Respondent are incomplete, inadequate and did not note important clinical data known at the time of admission;

d) the Respondent failed to review each resident's total program of care, including medications and treatments at each visit as required by 42 CFR §483.40 and failed to date orders which had been previously issued;

e) the Respondent did not fulfill his required duties as medical director regarding the implementation of resident care policies, and coordination of the medical care at the facility as required by 42 CFR §483.75(2)(ii)(1).

7. The Board finds the Respondent guilty of unprofessional conduct as defined by §5-37-5.1(19) and for failure to adhere to the standards for a Medical Director of a Long Term Care Facility as required by federal law.

The parties agree as follows:

(1) The Respondent is a physician licensed and doing business under and by virtue of the Laws of the State of Rhode Island, Osteopathic license No. 272. Respondent's mailing address is 1133 Main Street, Chepachet, Rhode Island 02814.

(2) Respondent admits to the jurisdiction of the Board and hereby agrees to remain under the jurisdiction of the Board.

(3) Respondent has read this Consent Order and understands that it is a proposal of Investigating Committee I of the Board and is subject to the final approval of the Board. This Consent Order is not binding on respondent until final ratification by the Board.

(4) Respondent hereby acknowledges and waives:

a. The right to appear personally or by counsel or both before the Board;

b. The right to produce witnesses and evidence in his behalf at a hearing;

c. The right to cross examine witnesses;

d. The right to have subpoenas issued by the Board;

e. The right to further procedural steps except for specifically contained herein;

f. Any and all rights of appeal of this Consent Order;

g. Any objection to the fact that this

Consent Order will be presented to the Board for consideration and review;

h. Any objection to the fact that it will be necessary for the Board to become acquainted with all evidence pertaining to this matter in order to review adequately this Consent Order;

i. Any objection to the fact that potential bias against the Respondent may occur as a result of the presentation of this Consent Order.

(5) If the Consent Order is not accepted by the Respondent, the Investigative Committee will convene an Administrative Hearing with respect to any and all acts of alleged unprofessional conduct.

(6) Acceptance of this Consent Order constitutes an acknowledgement by the Respondent of the findings of the Investigating Committee.

(7) This Consent Order shall become part of the public record of this proceeding once it is accepted by all parties and by the Board. It shall be published as the Board, in its exercise of its discretion, shall determine.

(8) Failure to comply with this Consent Order, when signed and accepted, shall subject the Respondent to further disciplinary action.

(9) The Respondent accepts the sanction of a Three (3) Month Suspension from the practice of medicine which shall be Stayed followed by a three year period of probation. The Respondent shall make arrangements for and complete, in addition to his basic requirements, Twenty (20) hours of Category 1 Continuing Medical Education (CME)to be approved, in advance, by the Board. The Respondent may not continue to care for patients in Long term Care facilities until he completes 20 hours of CME in the area of Gerontology approved in advance by the Board.

(10) The Respondent shall be on Probation for three years. If the Board allows the Respondent to return to the care of elderly residents in Long term care facilities, he will do so under the supervision of the Medical Director of the facility or facilities. The Respondent will arrange for a monthly report from the Medical Director(s) to the Board of Medical Licensure and Discipline with specific information regarding documentation in the medical record as set forth in the investigative findings of this order.

(11) The Respondent shall pay an Administrative Fee of One Thousand ($1000.00) Dollars to the Board within sixty days of ratification of this Consent Order. This Order is in full satisfaction the Board's review of all of the Respondent's issues arising out of his care and treatment of patients at Meadow Glen Health Center.

Signed this 8th day of April 1997.

Clayton D. Lanphear III, D.O.

Ratified by the Board of Medical Licensure and Discipline at a meeting held on April 9, 1997 1997.

Patricia A. Nolan, MD, MPH

Patricia A. Nolan, MD, MPH
Chairperson
Board of Medical Licensure and Discipline